

County of San Diego

Low Income Health Program (LIHP)

9.19.11

**Provider Handbook
September 2011**

County of San Diego Low Income Health Program (LIHP)
Provider Handbook

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Section 1 Low Income Health Program

The San Diego Low Income Health Program (LIHP) is designed as a program for eligible adults, which covers a core set of physical and mental health services.

LIHP consists of 2 components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI).

- MCE – covers individuals with income up to and including 133% of the Federal Poverty Level (FPL).
- HCCI – covers individuals with income above 133%, up to and including 200% FPL.

San Diego's LIHP will offer new enrollment to the MCE portion of the LIHP. Enrollment into HCCI will be limited to those individuals already enrolled in Coverage Initiative who have income within the HCCI range, and who continue to meet eligibility criteria and requirements. There are no cost sharing (monthly premiums or share of cost) or co-payments required in the LIHP.

LIHP is managed for the County of San Diego by the Administrative Services Organization (ASO). Participating medical and mental health providers contract with the County of San Diego. A list of participating primary care providers, mental health providers, and hospitals can be found in Attachment F. The ASO handles enrollee services, health service appeals, authorizations, claims processing and payment.

Health care is available to LIHP certified enrollees (thereafter referred to as "enrollees" when LIHP certified, and as "individuals" if eligibility has not yet been determined), within the Scope of Care and according to the LIHP Medical Policy and LIHP Specialty Care Guidelines, at the following service locations:

- Primary Care Services: Covered without prior authorization at network Community Health Centers at the enrollee's assigned site.
- Specialty Provider Services (including Mental Health Services): Covered with prior authorization with network providers. Authorization will be automatic for enrollees receiving mental health services through the County or its contractors at the time of the LIHP implementation (see Psychiatric Guidelines of LIHP Medical Policy). Enrollees entering the LIHP after the LIHP implementation, who have been receiving mental health services, will be reviewed by the ASO for continued services at their existing mental health provider.
- Out-of-network second opinions must receive prior approval.
- Ancillary Services: Covered with prior authorization within the LIHP Scope of Services.
- Emergency Department Services: Emergency and post-stabilization services are covered. Out-of-network emergency services and post-stabilization services are paid according to Centers for Medicare and Medicaid Services and Special Terms and Conditions (STC) 63 (f).

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- Acute Hospital Admissions: Covered at all San Diego County hospitals for physical health conditions. The single authorization number covers services associated with the hospital stay, including physician services. This authorization includes one follow-up visit with the attending physician within thirty (30) days of discharge. Additional post-discharge visits and/or services, including any post-discharge imaging or procedures, require authorization from the ASO.
- Mental Health Hospital Admissions: Covered at network hospitals (free-standing hospitals, for 19 and 20 year-olds only) for mental health conditions meeting medical necessity criteria, as established by Medi-Cal regulations. The single authorization number covers services associated with the hospital stay, including physician services. This authorization includes one follow-up visit with the attending physician within thirty (30) days of discharge. Additional post-discharge visits and/or services, including any post-discharge imaging or procedures, require authorization from the ASO.
- Scheduled Hospital Admissions: Covered with prior authorization. Approval is based on the LIHP scope of services and medical necessity.
- Supplemental Services: Primary care providers may authorize limited diagnostic procedures and supplies as designated on the Supplemental Services Form, without needing prior authorization from the ASO.

LIHP Enrollment Cap

When the County determines the LIHP enrollment is at its maximum level relative to funding available, the County will notify the LIHP providers. Individuals enrolled in the LIHP at the time an enrollment cap is placed will remain enrolled as long as they continue to meet eligibility requirements. Providers will continue to be paid according to the LIHP payment schedule for active and eligible LIHP enrollees.

Handbook – Online Version

The following link can be used for accessing the online version of this handbook:

http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

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Important Numbers

AmeriChoice Numbers and Addresses

LIHP Provider Line (Authorizations, Program Information)	(858) 658-8650
LIHP Provider Fax	(858) 658-8669
LIHP Provider Claims Line (Claims/Payments)	(858) 495-1333
AmeriChoice Program Operations	(858) 492-4422
LIHP/AmeriChoice Fax Number	(858) 565-4091
LIHP/AmeriChoice Address:	PO Box 23667 San Diego, CA 92193
AmeriChoice County Mail Station	0557B

County Administration Numbers and Addresses

LIHP Program Administration Phone	(858) 492-2222
LIHP Program Administration Fax	(858) 492-2265
LIHP Program Administration Address	PO Box 85524, MS 0557A San Diego, CA 92186-5524
Compliance Office (to report provider fraud, waste and abuse)	(619) 515-4246
Privacy Office	(619) 515-4243
ACCESS	(866) 262-9881 or pubassist.HHSA@sdcounty.ca.gov

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Section 2 Eligibility

To be eligible for the LIHP services, an individual must:

- Be a US citizen or meet eligible alien criteria
- Be a resident of San Diego County based on the LIHP eligibility criteria
- Be 19 through 64 years old
- Not be linked or eligible to Medi-Cal (age, blind, CalWORKS, or disabled)

Financial Criteria

Financial eligibility criteria for the LIHP are based on income.

Citizenship/Eligible Alien Status

Individuals must be a U.S. Citizens or eligible alien. U.S. citizens may be asked to provide original citizenship and identity documentation. Eligible aliens must provide proof of alien status before certification.

Residency

Individuals must live in a primary residence located in San Diego County and must provide proof of residence before certification. A fixed address is not required. Individuals living on the streets or in a vehicle can be county residents. Individuals visiting from other counties, states, or countries are not eligible.

Where to Apply for the LIHP

Individual may apply for the LIHP at the following HHSA locations:

- Centre City, 1255 Imperial Avenue, 5th Floor, San Diego, CA 92101
- El Cajon, 220 S. First Street, El Cajon, CA 92019
- Lemon Grove, 7065 Broadway, Lemon Grove, CA 91945
- North Central, 5055 Ruffin Road, San Diego, CA 92123
- North Coastal, 1315 Union Plaza Ct., Oceanside, CA 92054
- North Inland, 620 E. Valley Parkway, Escondido, CA 92025
- Northeast, 5001 73rd Street, San Diego, CA 92115
- South, 690 Oxford Street, #E, Chula Vista, CA 91911
- Southeast, 4588 Market Street, San Diego, CA 92102

LIHP Eligibility

Individuals apply for LIHP eligibility by completing an application and providing verifications to an HSS. The HSS reviews the application and verifications, and makes the decision to approve or deny. If approved, an LIHP Member card and Enrollee Handbook will be mailed to the enrollee. Enrollees are approved for a period of up to 12 months.

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Retroactive Coverage

The LIHP/MCE offers 1 month retroactive coverage. If an individual received services in the month prior to their date of application for the LIHP/MCE, they should advise the eligibility worker that they wish to apply for the LIHP/MCE retroactive coverage. Retroactive coverage cannot be approved for any month prior to the LIHP implementation, July 2011. The individual may be required to provide additional documentation relating to the retroactive month. This is a separate eligibility evaluation process, and a separate notice will be sent to the applicant to advise them whether they have been approved or denied for the retroactive month.

LIHP Member Card

Enrollees approved for the LIHP will receive a Notice of Action (NOA) and LIHP Member Card. The Member card and NOA are not proof of eligibility and do not authorize services. Eligibility for individuals who applied for the LIHP after January 22, 2011 should be verified on the Provider CMS Provider Online Verification (POV) website: www.sdcmispov.com

The POV site is available only to network providers. Refer to Section 14 for information on how to become a network provider.

Example of the LIHP Card is shown below.

Front

COUNTY OF SAN DIEGO
LOW INCOME HEALTH PROGRAM
P.O. BOX 85222
SAN DIEGO, CA 92186-5222
Phone (800)587-8118



Name: John Smith
Member ID #: AB-123-987
Medical Home (PCC): Ocean Clinic
PCC phone #

Eligibility Verification:
www.sdcmispov.com

Back

1. If you have a medical need, call your primary care clinic. They can provide or arrange for the care you need.
2. If you have a medical emergency, go to an Emergency Room or dial 911.
3. All services, except community clinic and emergency room visits, must be approved in advance by LIHP.
4. If you alter or misuse this card, falsify information, or stop meeting LIHP requirements, your eligibility may stop before the thru date. Legal action may be taken if you use this card after loss of eligibility.
5. Emergency Services rendered by an out-of-network provider are reimbursable by the County of San Diego LIHP (LIHP) if LIHP is notified within 24 hours of emergency room admittance, and if post-stabilization care meets approved protocols set forth by LIHP. Fax information to (858) 658-8669
6. You must use all other health insurance before LIHP.
Other Insurance: _____
Patient's Signature: _____
Date Issued: _____

Fraud Referral

If you suspect that an enrollee has an LIHP card but is not eligible for the LIHP, call the Patient/Provider Coordinator at (858) 492-4422 and report the individual's name, address, birth date, Social Security number and the reason you suspect fraud. Anonymous reports are accepted.

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If you suspect fraud, waste, or abuse of the LIHP system by a provider, please contact the County Compliance Officer at (619) 515-4246 or by e-mail, at Compliance.HHSA@sdcounty.ca.gov. You may request that your identity be kept confidential.

Section 3 Medical Policy and Scope of Services:

Physical and Mental Health

Policy

The Low Income Health Program (LIHP) is a medical assistance program servicing low income and indigent adult residents of San Diego County. LIHP provides physical and mental health services when the LIHP Medical Policies and Specialty Care Guidelines are met. The LIHP/County Medical Services (CMS) Medical Director or designee can deny services if established LIHP criteria are not met. The provider and the enrollee have the right to appeal any LIHP decision that denies a medical or mental health service.

The following provides a general overview of the LIHP medical criteria and covered services. LIHP Policies on Appeals and Grievance delineate the standards for this process.

LIHP Mental Health Scope of Services:

The LIHP will provide coverage for limited mental health care for an eligible enrollee who meets all three of the following criteria:

1. The LIHP enrollee must be diagnosed by an LIHP participating provider, within their scope of practice, with a mental health diagnosis specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.
2. The enrollee must demonstrate at least one of the following impairments as a result of the diagnosed mental disorder.
 - i. A significant impairment in an important area of life functioning.
 - ii. A probability of significant deterioration in an important area of life functioning.

“Significant impairment” may, for instance, include risk of self-harm or injury to others; loss of ability to provide for food, clothing and shelter; somatization necessitating unnecessary medical visits or procedures; loss of employment; loss of stable psychosocial support system, and risk of further deterioration of mental status or emotional state likely to result in the development of more severe pathology.

3. The intervention recommended by the LIHP participating provider, within their scope of practice, must be reasonably calculated to:
 - i. Significantly diminish the impairment; or
 - ii. Prevent significant deterioration in an important area of life functioning.

LIHP Medical Policies and Specialty Care Guidelines

The LIHP covers physical health care and limited mental health care when an enrollee’s health condition or symptoms fall within the LIHP Scope of Services. LIHP Medical Policies and

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Specialty Care Guidelines, as well as Milliman Care Guidelines, are used to determine authorization of specific physical or mental health services or treatments.

LIHP Medical Policies and Specialty Referral Guidelines can be found on-line at:

http://www.sdcountry.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

LIHP Medical Policies also include Psychiatry Guidelines and Preventive Care Guidelines.

Covered Services

The following benefits are covered for enrollees of the LIHP and **do not** require prior authorization:

- Evaluation and follow-up care by a primary care provider at the enrollee's designated primary care site
- Emergency room care for emergent conditions
- Emergent outpatient mental health services (including urgent walk-in triage and assessment)
- Emergency medical transportation
- Emergency dental care
- Pharmaceuticals listed as formulary medications on the LIHP Formulary.
- Acute inpatient hospital services
 - Through the hospital emergency department or as a direct admit from the provider/clinic
 - Notification to the ASO is required:
 - Notification of physical health inpatient admissions follow the existing Daily Census process
 - For mental health inpatient admissions, the hospital will notify the ASO by calling 1-800-295-0956 within 24 hours of admission
 - Limited to 10 days per year for acute mental health hospitalization (includes administrative inpatient days)
- Translation services (see Attachment D)

The following benefits are available to LIHP enrollees **only by prior authorization**:

- Limited preventive medical services
- Medical equipment and supplies
- Scheduled inpatient hospital admissions and services
- Prior-authorized non-emergency medical transportation (when medically necessary, required for obtaining health care and provided for the lowest cost mode available)
- Outpatient hospital services
- Physical therapy

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- Specialty physician services (including mental health); with mental health benefits as described below
 - Up to 12 mental health outpatient encounters per fiscal year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. Mental health specialty encounters from the previous fiscal year do not roll-over to the new fiscal year.
- Prosthetic and orthotic appliances and devices
- Podiatry
- Surgical and diagnostic procedures
- Limited home health services
- Optometry exams and supplies
- Non-formulary prescription medications (all prescriptions must be approved by the FDA)

Non-covered Services

The following services/diagnoses are excluded from LIHP coverage and are **NEVER** reimbursed:

- Bariatric surgery
- Pregnancy and all prenatal services
- Pediatric services
- Family planning and sterilization procedures
- Infertility related services
- Drug and alcohol treatment
- Organ and bone transplants and all services related to obtaining a transplant
- Bone marrow transplants
- Experimental procedures
- Cosmetic procedures in the absence of trauma or significant pathology
- Work examinations
- Completion of medical certificates
- Routine or preventive dental services
- Orthodontia
- Non-FDA-approved medications
- Emergency room visits for after care, follow-up, and to obtain prescriptions
- Medical or Clinical trials, including any medication, treatment, procedure, or professional component related to any clinical trial in which the LIHP enrollee may be involved
- Electroconvulsive therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Vagal Nerve Stimulation
- Observation status (hospital admission for less than 24 hours)

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Second Opinion

LIHP will authorize an enrollee or physician request for a second opinion when one of the following circumstances is present:

- A more cost-effective treatment option is available.
- Conservative therapy has not been attempted or has not had sufficient time to show results.
- The physician or enrollee disagrees with the diagnosis and/or the plan of treatment recommended by the specialist.
- Patient/provider relationship is hindered.
- Geographic and/or other obstacles prohibit the enrollee from accessing care.

If the second opinion is requested of a specialty provider, a Treatment Authorization Request (TAR) must be submitted. Second Opinions will be directed to network providers. Out-of-network providers will only be utilized if the services are not available in network.

Section 4 Primary Care Clinics

During the application process, enrollees select a “medical home” or Primary Care Clinic site, where they receive their primary health care. Authorization is not needed for primary care medical visits to the enrollee’s primary clinic site and non-specialty mental health visits conducted at the primary care site; however, health conditions must be within the LIHP Scope of Services. Specialty visits at the primary clinic site do require prior authorization, however the first visit for a specialty mental health visit at the primary care site (or the mental health site) can be conducted prior to TAR submission. Enrollees may change their selection of a medical home upon request through the ASO.

Each enrollee selects a clinic site and must be seen at that site for their primary care services. Primary care services provided at a site other than their designated clinic site will not be reimbursed, except under the following conditions:

- Disease management and care coordination services can be provided at any site within the parent clinic organization. These include but are not limited to group visits, health education, nutrition, and CDE visits. Refer to Section 13 for information related to reimbursement.
- Urgent visits may be conducted at another site within the parent clinic organization if the assigned site does not have capacity to meet access requirements.
- An enrollee may see his/her Primary Care Provider at any site within the parent clinic organization.

A primary care visit includes:

- A face-to-face encounter with a physician, physician’s assistant or nurse practitioner for the purpose of examination, diagnosis and treatment of the presenting or chronic medical and or mental health condition. Primary care providers may practice family medicine, general medicine, or internal medicine.
- All nursing and supportive services, supplies and equipment provided during the encounter.

A primary care visit may include:

- Nutritional counseling and health education (not reimbursed separate from the visit)
- Mental health care and medication management
- Diagnostic laboratory tests customarily done by the clinic during a primary care visit
- Plain radiographs
- Simple procedures (vision test, hearing test, and EKG)

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Referrals

Authorization is needed for diagnostic tests and professional care that are outside a primary care scope of practice. A two tiered authorization process is used to authorize non-clinic services. See Section 10 for Authorization Process

Treatment Authorization Request Forms are available on-line at:

http://www.sdcountry.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

Application Assistance

Each primary care site shall assist community residents with the LIHP application process by:

- Assisting applicant in completing the LIHP application forms.
- Assisting the applicant in gathering the verifications as needed during their eligibility process.
- Advising LIHP applicants that they may be required to provide additional verification, including any verifications/documents required by Medi-Cal or County Medical Services (CMS).

Designated Care Coordination Responsibility

- Each primary and specialty care site (including mental health) shall formally designate one staff member who is primarily responsible for coordinating enrollees' health care services. If the same staff member can fulfill these duties at multiple sites, that is acceptable.
- This staff will be available to the ASO to collaborate with efforts to provide care coordination and case management.

Other primary care services and requirements may be found in the LIHP Primary Care Medical Home (PCMH) table (Attachment A). In addition, measures required in the annual LIHP Quality and Utilization Management and QM Plan (Attachments C & E) must be provided to the ASO in the designated report format on a quarterly basis.

Care Management requirements are listed in Attachment C, LIHP Quality and Utilization Management.

Healthcare Effectiveness Data and Information Set (HEDIS) Measures are listed in Attachment E.

Primary Care Provider Required Training requirements are listed in Section 7.

Dental Services

Emergency dental services are available to LIHP enrollees. Services are limited to urgent and emergent conditions due to trauma or to alleviate acute pain associated with dental pathology. LIHP Dental Locations are listed in Attachment F.

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Pharmacy Services

- LIHP covers prescribed medications for all pharmaceuticals listed as formulary medications on the LIHP Formulary. (All prescriptions funded by the LIHP must be approved by the FDA). The LIHP pharmacy benefit management company processes formulary exceptions. The LIHP formulary is modified on a periodic basis, and updates are available to all participating pharmacy vendors and prescribing clinicians. The directions for obtaining non-formulary prescriptions are detailed in the instruction section of the LIHP formulary. The formulary and instructions/forms to request non-formulary pharmaceuticals are available on-line at: http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

Pharmacies may dispense up to a maximum of a thirty (30) day supply. The clinician determines the appropriate number of refills when prescribing maintenance drugs, however the prescriptions may be written for the full time period permitted by law.

In some circumstances the pharmacy may request more information from the prescribing provider, who is expected to reply promptly so as not to delay care. Requests for medications that are non-formulary and not covered by the LIHP will be referred to the Patient Assistance Program. It is the responsibility of the prescribing physician, or designee, to submit the PAP application.

Section 5 Mental Health Providers

There are 4 types of mental health organizations where the LIHP enrollees may access outpatient care:

- County Operated mental health sites
- County Mental Health contract organizational providers
- FQHC Mental health sites
- FQHC Primary care sites

Designated Care Coordination Responsibility

- The Program Manager or designee at each mental health site shall be responsible for coordinating enrollees' health care services.
- The Program Manager or designee will be available to the ASO to collaborate with efforts to provide care coordination and case management.
- Peer support staff and peer specialist volunteers at Clubhouse may be enlisted to assist MCE clients in enrollment process.

County Providers

- Mental Health clinicians identify existing patients potentially eligible for the LIHP.
- Patient is referred to the County Uniform Methods of Determining Ability to Pay (UMDAP) worker to apply for the LIHP.
- County UMDAP worker processes the LIHP application and determines eligibility.

County Mental Health (MH) Organizational Providers (Contracted MH Clinics)

Each County Mental Health Organizational site shall assist community residents with the LIHP application process by:

- Assisting applicant in completing the LIHP application forms.
- Assisting the applicant in gathering the verifications as needed during their eligibility process.
- Advising the LIHP applicants that they may be required to provide additional verification, including any verifications/documents required by Medi-Cal or County Medical Services (CMS).

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Section 6 Hospital Based Services

Inpatient Services

Inpatient services are defined as those physical or mental health services provided by a physician to an enrollee who is admitted to a hospital for 24 hours or more. LIHP network hospitals are required to notify the ASO within one business day of every admission of an LIHP (or known pending LIHP) enrollee.

LIHP Provider Fax (858) 658-8669
For mental health admissions..... (800) 295-0965

- Payment of services to the hospital is subject to concurrent and retrospective reviews by the ASO. All approved facility and physician payments will be made by the ASO.
- Notifications of emergency admissions are processed and claims are paid only when eligibility is confirmed. Authorization numbers are not released until the eligibility process is complete.
- When a County electronic health information exchange system becomes available, the hospitals will submit the enrollee's discharge summary and discharge instructions within 1 business day of discharge. Until available, hospitals are encouraged to fax discharge summaries within 14 days to the enrollee's designated primary care site as specified on the enrollee's verification of eligibility.

Scheduled Admissions and Outpatient Surgery

Scheduled, non-emergent admissions and outpatient surgical procedures, including pre-operative diagnostic tests, must receive prior authorization by the ASO Medical Management staff. Prior approval includes pre-operative diagnostic tests for scheduled surgical admissions and outpatient surgery. These procedures must be provided during the approved time period.

Enrollee Follow-up After Hospital Discharge

One (1) follow-up office visit by the attending physician within 30 days of discharge is included in the authorization for admission, excluding laboratory and x-ray services which require separate authorization.

Emergency Department Services

Emergency Department (ED) services, including specialty physician care provided in the ED, are covered when provided in any San Diego County acute care hospital for LIHP certified patients. The emergency condition must be within the LIHP Scope of Services. Payment for services includes coverage for the specialty physicians providing care in a network emergency

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department, but professional and facility services will be billed separately and reimbursed according to the terms of the contract.

LIHP network emergency departments are required to notify the ASO within one business day of treating an LIHP (or known pending LIHP) enrollee in the Emergency Department.

When a County electronic health information exchange system becomes available, the hospitals will submit the enrollee's discharge summary and discharge instructions within 1 business day of discharge. Until available, hospitals are encouraged to fax discharge summaries within 14 days to the enrollee's designated primary care site as specified on the enrollee's verification of eligibility.

LIHP Provider Fax (858) 658-8669

In order for an ED claim to be paid, the following conditions must be met:

- The individual must be certified LIHP eligible for the date of service.
- The condition must be included in the LIHP Scope of Services.
- The emergency department of an LIHP network hospital must be listed as the place of service on the claim form.

For out of network ED visits, please see Out-of-Network Requirements below.

Emergency Department Follow-up Care

Follow up care for LIHP enrollees with their assigned primary care provider is covered without prior authorization. Request for specialty care visits must be submitted by the primary care provider to the ASO for prior authorization.

- As stated previously in this document, Emergency Department Visits for after-care, follow up, suture removal or for the sole purpose of obtaining a prescriptions are not covered benefits.

Out-of-Network Requirements

Participating counties under the LIHP must provide coverage of emergency services provided in hospital emergency departments for emergency medical conditions and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the LIHP network.

LIHP programs may pay for emergency services and post-stabilization services provided by out-of-network providers at the specified non-network payment amount of 70% of in-network payment schedule. The out-of-network provider must accept the LIHP program payments made as payment in full for the services rendered, and the LIHP enrollee may not be held liable for payment.

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Out-of-network providers must, as a condition for receiving payment for emergency services, notify the LIHP program within 24 hours of treating the patient in the emergency department, and, with respect to post-stabilization care, meet the approval protocols established by the LIHP program.

LIHP Provider Line (Authorizations, Program Information) (858) 658-8650 or

LIHP Provider Fax (858) 658-8669

Section 7 Additional Requirements of Primary and Specialty Outpatient Service Providers

Designated Care Coordination Responsibility

- Each provider shall formally designate one staff member who is primarily responsible for coordinating enrollees' health care services.
- This staff will be available to the ASO to collaborate with efforts to provide care coordination and case management.

Case Management

Case Management requirements are listed in Attachment C, LIHP Quality and Utilization Management. Care coordinators assigned to a provider site are expected to:

- Coordinate an enrollee's care with the ASO, the primary care site, specialty site, the hospital and the Emergency Department.
- Coordinate care if over and/or under utilization of services is recognized.
- Address outliers in risk and quality indicators.

Other Requirements

Primary care medical home definition of services and requirements are included in Attachment A.

Provider training may include cultural competency, due process, credentialing, quality management and data reporting, claims and billing, authorization processes, eligibility/program requirements, case management, and general information on the LIHP.

All providers must follow requirements in the annual Quality and Utilization Management Plan (Attachments C & E).

Providers must meet cultural and linguistic needs of the LIHP enrollee (Attachment D).

Providers must advise enrollee of their right to obtain Advanced Directive information.

Section 8 Ancillary Services

Ancillary Health Services and Supplies

Treatment Authorization Requests (TARs) for Ancillary Health Services and Durable Medical Equipment (DME) are approved when they meet the LIHP Medical Policy Guidelines and Milliman Care Guidelines. Examples of Ancillary Health Services and Durable Medical Equipment (DME) include (but are not limited to):

- Home health services (including nursing, physical, speech and occupational therapy provided in the home)
- Home Infusion
- Rehabilitation Therapy (outpatient physical, speech or occupational therapy)
- Hearing Aids

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Section 9 Pharmacy Services

Pharmacy Services

- LIHP covers prescribed medications for all pharmaceuticals listed as formulary medications on the appropriate LIHP Formulary.
- All prescriptions funded by the LIHP must be approved by the FDA and filled at LIHP Network Pharmacies (see listing on the LIHP website).
- Pharmacies may dispense up to a maximum of a thirty (30) day supply. The clinician determines the appropriate number of refills when prescribing maintenance drugs, however the prescriptions can be written for the full time period permitted by law.
- Requests for medications that are non-formulary and not covered by the LIHP will be referred to the Patient Assistance Program. It is the responsibility of the prescribing physician to submit the PAP application.
- The directions for obtaining non-formulary prescriptions are detailed in the instruction section of the LIHP formulary. The LIHP pharmacy benefit management company processes formulary exceptions.
- The formulary and instructions/forms for non-formulary prescriptions are available on-line at:
http://www.sdcounty.ca.gov/hhsa/programs/ssp/low_income_health_program/index.html
- The LIHP formulary is modified on a periodic basis, and updates are available to all participating pharmacy vendors and prescribing clinicians through the web site address above.
- The list of participating pharmacies can be found at:
http://www.sdcounty.ca.gov/hhsa/programs/ssp/low_income_health_program/index.html

Pharmaceutical Prior Authorization Request (PAR)

To obtain authorization of a non-formulary medication, complete the LIHP Drug Prior Authorization Request form and fax the request to:

informedRX, Inc., the LIHP Pharmacy Benefit Manager:
(800) 945-1815

Urgent PARs may be called to informedRX, Inc at (800) 777-0074

In some circumstances the pharmacy, Pharmacy Benefit Manager (PBM), or ASO may request more information from the prescribing provider, who is expected to reply in an appropriate timeframe so as not to delay care.

Section 10 Referrals

Referrals

As possible, referrals should be initiated by the enrollee's primary care provider to ensure continuity and coordination of care.

Eligibility for individuals who applied for the LIHP after January 22, 2011 must be verified on the Provider CMS Provider Online Verification (POV) website: www.sdcmspov.com prior to submitting a referral to the ASO.

The POV site is available only to network providers. Refer to Section 14 for information on how to become a network provider.

Treatment Authorization Requests (TARs)

To initiate a Specialty referral, the provider shall submit a Treatment Authorization Request (TAR) to the ASO. The ASO Medical Management Services Department reviews TARs from primary care and specialty physicians for medical necessity and to verify that services are within the scope of the LIHP covered services and meet the LIHP Medical Policy and Specialty Care Guidelines. Current Milliman Care Guidelines also are utilized by the ASO in adjudicating TARs. In addition to admissions, surgical procedures, ancillary/supportive services, and specialty care services, the following (not an exclusive list) require authorization from the ASO's Medical Management:

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Diagnostic Studies	Consults	DME
<ul style="list-style-type: none"> ▪ CT Scan ▪ Diagnostic mammogram if not covered under other indigent programs. ▪ MRI ▪ Non-formulary products ▪ Nuclear studies ▪ P.E.T. Scan ▪ Simple biopsy by a Dermatologist ▪ Sleep Studies (Attach sleep study form) ▪ EMG, Limited ▪ Nerve conduction study 	<ul style="list-style-type: none"> ▪ Cardiology ▪ Dermatology ▪ Endocrinology ▪ ENT ▪ Gastroenterology ▪ Gynecology ▪ Hernia repair evaluation (with work history form completed) ▪ Mental Health Services ▪ Nephrology ▪ Neurology ▪ Neurosurgery ▪ Oncology ▪ Ophthalmology ▪ Optometry ▪ Orthopedics ▪ Pain Management ▪ Physical Therapy (evaluation only) ▪ Podiatry ▪ Pulmonology ▪ Psychiatry ▪ Rheumatology ▪ Specialty Mental Health Services ▪ Surgery ▪ Urology 	<ul style="list-style-type: none"> ▪ All DME that meet LIHP Medical Policy criteria and received TAR approval

The following diagnostic studies, radiographs and DMEs do not require authorization

Diagnostic Studies	Radiographs	DME
<ul style="list-style-type: none"> ▪ Audiogram ▪ Cardiovascular stress test (Treadmill) ▪ Doppler 	<ul style="list-style-type: none"> ▪ Barium enema ▪ Barium swallow ▪ IVP ▪ Sonogram 	<ul style="list-style-type: none"> ▪ Crutches ▪ Elastic support brace ▪ Standard one point cane

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- Echocardiogram
- EEG
- PFT
- Diagnostic Sigmoidoscopy
- Holter monitor
- Ultrasound
- Upper GI
- X-rays – 4+ views

Physicians and mental health providers must submit the TAR to the ASO with sufficient information to support the requested medical or mental health service. TARs may be submitted electronically via eTAR or on an LIHP/CMS-19, LIHP/CMS Program Request for Referral Services Form. Information required with each TAR is delineated in the LIHP and CMS Medical Policies and the LIHP and CMS Specialty Referral Guidelines and includes documentation of the patient's history, physical exam, and appropriate diagnostic studies. These resources can be found at: http://www.sdcounty.ca.gov/hhsa/programs/ssp/county_medical_services/index.html

All TARs must be ordered by a physician or co-signed by a physician for physical health services. TARs ordered by a midlevel provider without a physician signature will be denied. TARs for mental health services may be ordered by a physician or a licensed, registered, or waived mental health clinician.

Turnaround time for ASO adjudication of routine TARs is five to seven working days. Complete, accurate and legible information will ensure a prompt response from the ASO.

Urgent TAR

The ASO will process a TAR as "urgent" when services are needed because of an enrollee's immediate medical or mental health condition, as documented in the referral. In addition to the usual patient identification, the medical service needed and sufficient information to establish the medical urgency must be provided to the ASO. Legibility and appropriate documentation is essential in order to process the TAR in a timely manner.

If the enrollee's condition is life threatening, refer the enrollee to the nearest LIHP network hospital or call 911. Emergency care does not require prior approval; medically necessary ambulance service is covered for eligible patients when taken to a contracted hospital.

Approvals

The ASO will provide each clinic the status of their processed TARs electronically via eTAR on a daily basis. The referring physician or mental health provider (not hospital facility) is responsible for notifying the enrollee of the approved referral, making the enrollee's

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appointment for the referred service, and forwarding appropriate medical information to the specialist.

If the enrollee's eligibility is pending or has expired, the ASO will not release the authorization number until the eligibility has been determined. The ASO will send notification indicating approval or denial of the TAR once the eligibility status has been entered into the claims processing system.

Returns and Denials

Administrative Returns

The ASO may return a TAR for administrative reasons. An Administrative Return is issued for all TARs received without any medical documentation and for all duplicate requests.

The ASO may deny a TAR for the following reasons:

- TAR documentation does not address the reason for the referral (insufficient information to make a medical determination).
- The service requested is not within the LIHP scope of services.
- The request is illegible.
- The required supportive documentation and forms are not submitted with the request.

Providers are notified of denials electronically via eTAR and via the Treatment Authorization Request (TAR) LIHP/CMS Administrative Denial Form, which is mailed to the ordering provider and the Daily Processed TAR Report, which is faxed.

Service Denials

Referrals that pose any uncertainty about medical necessity or conformity with the LIHP Scope of Services, LIHP Medical Policy, LIHP Specialty Care guidelines or Milliman Care Guidelines will be referred to the ASO Medical Director or designee for final determination. Providers will be notified of the denial in the same manner as other denials.

Enrollees are notified of medical and mental health service denials via a form generated from the claims processing system.

Please refer to Section 12 of this handbook for information concerning an enrollee's rights and processes of Grievance, Appeals, and State Fair Hearing.

Section 11 Network Adequacy and Access Requirements

Providers must meet standards for timely access to care and services, considering the urgency of the service needed as set by the State of California, Department of Health Care Services.

- Accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each enrollee's place of residence.
- Primary care appointments will be made available within 30 business days of request through June 30, 2012
- Primary care appointments will be made available within 20 business days for the period July 1, 2012 through December 31, 2013.
- Urgent primary care appointments will be provided within 48 hours (or 96 hours if prior authorization is required) of request.
- Urgent mental health services will be provided within 72 hours of request.
- Specialty care access (including mental health) shall be provided at a minimum within 30 business days of an urgent request and within 60 days for a non-urgent appointment until June 30, 2012. Beginning July 1, 2012 through December 31, 2013, the wait time for non-urgent appointment will not exceed 40 days.
- Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service (FFS) participants.
- Services under the contract must be made available 24 hours per day, seven days per week when medically necessary, which may include access to the LIHP 24 hour hotline.

Section 12 Grievances and Appeals

The LIHP Grievance and Appeal process provides a method for LIHP Program Administration and the ASO to investigate and resolve grievances and appeals filed by enrollees and providers. It also delineates enrollee rights. Please refer to the LIHP Appeals and Grievance Policy for more details (Attachment B).

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Section 13 Claims

The ASO processes all claims submitted by hospitals, clinics, specialty physicians and ancillary providers seeking payment from the LIHP.

Submission Requirements

All claims must:

- Be for services and service dates that match the certified enrollee's eligibility and period authorized.
- Primary care clinic claims must be submit electronically. When the enrollee has other health coverage (OHC), claims must be submitted to the other insurance carrier first. If then submitting the claim to the ASO, the other carrier's Explanation of Benefits (EOB) must be included.
- Include the following information:
 - Enrollee's name, birth date, and Social Security Number (or LIHP Member ID)
 - Date(s) of service
 - Place of service
 - Vendor and group name, address and phone number
 - Name and address of facility where services were rendered if different from the billing office
 - National Provide Identifier (NPI) – Individual and Organizational
 - Provider Tax Identification Number
 - ICD–9 Codes
 - Current RVS, CPT, HCPCS and Medi–Cal/Denti–Cal codes as indicated
 - Refer to Section IX (Definitions) for Mental Health provider encounter minutes standards
 - Authorization number (TAR control number)
 - Referring physician (required – Hospital and Ancillary only)
 - Full itemization of charges, including drugs and supplies provided
 - All documentation and attachments required by Medi–Cal
 - Catalogue page or invoice when submitting an unlisted or “miscellaneous” code, if applicable
- Are requested to be submitted within 30 days from the date of services or date of discharge to the current ASO:

AmeriChoice
LIHP Claims Office
PO Box 23667
San Diego, CA 92193

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Checking Claim Status

The ASO processes claims that are complete and accurate within 30 days of receipt. The ASO claims department may be reached at (858) 495-1333 if payment has not been received within 45 days of a claim.

Checks and the Remittance Advice (RA) are produced twice a month. LIHP reimbursement is considered payment in full. No payments are to be billed to or collected from the enrollee except as permitted below.

Primary Care Clinic (FQHC)

- Primary Care Visits at the FQHC clinic will be paid at individual Prospective Payment System (PPS) rates for covered services furnished to the LIHP enrollees, according to current Medi-Cal FQHC PPS billable "visit" regulations, as designated in the LIHP Primary Care Clinic Services contract.
 - If there is a change to an FQHC's PPS rate, FQHCs are to follow the procedures identified in Exhibit C-7 of their LIHP contract with the County of San Diego.
 - FQHCs will need to provide verification of any changes to their current PPS rate within 10 days of notification for the new rate to take effect.
- LIHP covered services linked to a face-to-face encounter with an approved clinician will be included in the PPS payment.
- Lab, radiology and pharmacy services not provided at the FQHC will be billed separately by the service provider and will be paid at FFS reimbursement schedule available from the ASO, assuming the services are covered benefits of the LIHP and prior authorization was obtained as appropriate.

Hospital Reimbursement

- All covered and authorized services provided by Hospitals will be paid as outlined in Exhibit C of the LIHP contract.

Specialty Reimbursement

- All covered and authorized services provided by Specialists will be paid as outlined in Exhibit C of the LIHP contract.
- Mental Health providers eligible to be covered as specialists include licensed, registered, or waived clinicians. Waivers are completed by the County of San Diego Behavioral Health Services.

Billing LIHP Enrollees

LIHP enrollees may not be billed for:

- Any balance of fees or other associated costs after the LIHP pays for the service(s).

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- Any hospital administrative errors (incorrect coding, failure to obtain timely authorization or late submission).

LIHP enrollees may be billed for:

- Non-authorized services.
- Services not covered in the LIHP Program Scope of Services.

Notification of Changes to Provider Information

To ensure your check and RA is accurate and timely, immediately notify the ASO's Claims Department at (858) 495-1333 of any changes in:

- Ownership
- Address (mailing and/or service site)
- Group affiliation
- Tax Identification Number (TIN)

Primary Care and Specialty clinics must provide the ASO's Claims Department with a listing of licensed or waived (by County of San Diego Behavioral Health Services) providers employed by the clinic who bill the LIHP for services (MD, DO, RNP, PA, PhD, LCSW, MFT, etc). Copies of license numbers and if applicable, DEA numbers are required. Staff changes and corrections should be forwarded to the ASO as they occur to avoid an unnecessary delay or denial of claims.

Credentialing

All licensed network LIHP providers with a formal agreement must undergo primary source verification for initial credentialing and re-credentialing every three years. Credentialing is performed by the ASO.

All waived mental health providers must obtain verification of status through County of San Diego Behavioral Health Services.

Medi-Cal Pending

LIHP covers necessary health care for certified enrollees while their Medi-Cal disability evaluation is pending. The ASO will process claims for these enrollees following standard LIHP procedures.

If the enrollee has latent tuberculosis or active tuberculosis, he/she is required to apply for TB-Cal.

In addition, if potential linkage to Medi-Cal has been identified, or the individual claims a disability, the individual will be required to apply for Medi-Cal.

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How to apply:

- Call 2-1-1
- Contact ACCESS:
 - via website <http://www.sdcounty.ca.gov/hhsa/programs/ssp/access/index.html> or
 - by phone at (866) 262-9881
- Apply for Medi-Cal on-line: <http://www.benefitscalwin.org/>
- Apply in person at the Family Resource Center

Medi-Cal Approved

The ASO will notify providers of the Medi-Cal approval on the Remittance Advice (RA). The ASO will deny all claims received after the enrollee has been approved for Medi-Cal. For claims the ASO has paid:

- Providers must bill Medi-Cal directly once Medi-Cal eligibility is approved
- In the event you receive payment from Medi-Cal for a service previously paid by the ASO, you must reimburse the LIHP via the ASO.

Death of an Enrollee Notification

Providers will inform the ASO using the appropriate discharge status code on the submitted claim. The ASO will also be notified during the concurrent review process, and the retrospective review

Appeal Process for Denied Claims

If a claim submitted to the LIHP for payment is denied, you may ask for an appeal and must resubmit the claim within 30 days of the denial notification. The reason for the appeal and additional justification for payment must be clearly stated. Send all claims for appeals to the following address:

**LIHP Program – Appeals
Attention: Claims Department
PO Box 23667
San Diego, California 92193**

Contact the ASO Claims Department at (858) 495-1333 for instructions about submitting an appeal. The ASO reviews the claim and additional information and communicates the decision within 45 calendar days.

End of Year Close-Out

The LIHP fiscal year ends on June 30 of each year. All claims for services provided to patients certified by or referred to the LIHP in a fiscal year, must be submitted to the ASO by July 31, regardless of authorization or eligibility status.

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Section 14 Contracts

All LIHP providers are required to establish and maintain a Compliance Program that meets or exceeds the requirements of 42 CFR 438.608.

Providers interested in becoming an LIHP Network Provider should contact the ASO at (858) 495-1373.

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Section 15 Definitions

Administrative Services Organization

The private organization retained by the County to provide administrative support to the LIHP.

County

County of San Diego, a political subdivision of the State of California.

Enrollee

An individual who has been approved for the LIHP benefits.

Emergency Medical Condition

Per Special Terms & Conditions (63): a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (b) Serious impairment to bodily functions.
- (c) Serious dysfunction of any bodily organ or part.

Health Home

The Health Home is designated as an FQHC that has received a first level PCMH recognition or higher. It also provides social support to assist enrollees in meeting basic needs such as shelter, food, and clothing. This encompasses the vision of Building Better Health and furthering the goals of *Live Well, San Diego!*

Individual

An applicant for the LIHP whose eligibility has not yet been determined.

Mental Health Provider Encounters

Covered Outpatient Service	Range of Minutes per Encounter	Encounter Duration (minutes)	CPT Code	HCPCS Code
Assessment (non-MD)	75+	90	90801	H2015-HE
Assessment (non-MD)- Brief	30-74	50	90801	H2015-HE
Medication Evaluation	31+	50	90801	H2010-HE

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Meds–Pharmacological Management	16–30	20	90862	H2010–HE
Med Check MD Brief	1–15	15	M0064	H2010–HE
Medication Support	15+	20	No CPT	H2010–HE
Individual Psychotherapy	45–60	50	90804	H2015–HE
Individual Psychotherapy–Brief	20–44	30	90804	H2015–HE
Individual Rehabilitation	45–60	50	No CPT	H2015–HE
Individual Rehabilitation–Brief	20–44	30	No CPT	H2015–HE
Group Psychotherapy	45–60	60	90853	H2017–HE
Group Rehabilitation	45–60	60	No CPT	H2017–HE
Crisis Intervention	61+	90	No CPT	H2011
Crisis Intervention– Brief	15–50	45	No CPT	H2011

An outpatient mental health encounter can include a behavioral health assessment, individual or group therapy, individual or group rehabilitation (for County and Contracted Organizational providers at Specialty Mental Health programs), crisis intervention, medication evaluation, and medication support.

Please use the HCPCS code for billing purposes if no CPT Code exists for the encounter.

Network Provider

A provider who has a contract with the County of San Diego to provide LIHP services.

Out-of-Network Provider

A provider who does not have a contract with the County of San Diego to provide LIHP services.

Primary Care Medical Home

A single provider, facility, or health care team that maintains an enrollee's medical information, and coordinates their health care services. The primary care medical home shall provide, at a minimum, all of the following elements:

- Facilitate the enrollee's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate.
- An intake assessment of each new enrollee's general health status.
- Referrals to qualified professionals, community resources, or other agencies as needed.

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- Care coordination for the enrollee across the service delivery system. This may include facilitating communication among enrollee's health care providers, including appropriate outreach to mental health providers.
- Care management, disease management, case management, and transitions among levels of care, if needed.
- Use of clinical guidelines, disease management, and other evidence-based medicine when applicable for treatment of the enrollee's health care issues and timing of clinical preventive services.
- Focus on continuous improvement in quality of care.
- Timely access to qualified health care interpretation as needed and as appropriate for enrollees with limited English proficiency, as determined by applicable federal guidelines.
- Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

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Attachment A – LIHP Primary Care Medical Home

LIHP Primary Care Medical Home
Definition of Services and Requirements
Functional and Operational Capabilities

1) Access and Continuity
a. Primary Care Appointment Access <ul style="list-style-type: none">♦ Written appointment standards and policies are in place consistent with LIHP policies♦ <i>Urgent:</i> Within 48 hours of request for both physical health and mental health complaints♦ <i>Routine:</i> 30 business days initial and 20 days effective 7/1/2012♦ Standards apply to patient or physician requests
b. County's electronic health information exchange system <ul style="list-style-type: none">♦ Conditioned on system availability and implementation
c. Telephone Access 24/7 <ul style="list-style-type: none">♦ <i>Normal Office Hours:</i> Telephone access for appointment-making and questions/concerns♦ <i>After Hours:</i> Telephone access for health questions/concerns through advice nurse/on-call♦ Consistent with access for Medi-Cal patients
d. After Hours Clinic Availability <ul style="list-style-type: none">♦ Same hours as accessible to Medi-Cal patients
e. Assigned Personal Clinician <ul style="list-style-type: none">♦ Each enrollee will select a medical home at the clinic "site" level♦ Expectation that enrollees will select a personal clinician whenever possible♦ Patients must be seen at assigned Medical Home site with following exceptions:<ul style="list-style-type: none">• If assigned site cannot meet Urgent Care request, patient may be seen at alternate contracted site of the parent organization• Chronic Disease management services may be provided at another contracted site of the parent organization including, but not limited to group visit, health education, nutrition and CDE visits• A scheduled follow up appointment with the enrollee's primary provider at an alternate contracted site of the parent organization.• Specialty care clinic visits (e.g., psychiatry, podiatry, ophthalmology, etc) must be adjudicated by a TAR which will allow the visit at any site within the parent organization.♦ Patient transport to alternate site may be provided by clinic, as needed; prior authorization

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for outside transport required (TAR)
f. Visits with Assigned Clinician/Care Team Member (continuity) <ul style="list-style-type: none"> ◆ Whenever possible, return visits/follow-up care will be scheduled with assigned clinician and site ◆ Assigned clinician team member acceptable (e.g., FNP, PA) ◆ Exceptions as noted under Assigned Personal Clinician 1.(e)
g. Electronic Health Records <ul style="list-style-type: none"> ◆ Electronic health records and other health information technology is encouraged.
h. Cultural/Linguistic competency and translation (primary, other) <ul style="list-style-type: none"> ◆ Culturally competent service delivery including translation 24/7 for clinic site languages as needed. Additional health care interpretive services accessed through designated LIHP service paid for by the County. ◆ Timely access to qualified health care interpretation, as needed and as appropriate for enrollees with limited English proficiency, as determined by applicable state and federal guidelines for clinics; ◆ Access to health care interpretive services, as needed and as appropriate, for enrollees with limited hearing and/or vision abilities ◆ Participation in Cultural Competency training
2) Identify and Manage Patient Population
a. Preventive services <ul style="list-style-type: none"> ◆ Provide preventive scope of services as defined in LIHP Preventive Health Policy ◆ Order preventive/screening services in accordance with Policy, including services requiring TAR
b. Assessment for Health Risks -- Behaviors – Interventions <ul style="list-style-type: none"> ◆ Intake assessment of each new patients general health status
c. Use of data for population management <ul style="list-style-type: none"> ◆ Work in conjunction with ASO Care Coordinators
3) Plan and Manage Care
a. Care Planning (protocols, criteria, plans)

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Attachment A – LIHP Primary Care Medical Home

<ul style="list-style-type: none"> ◆ Use of clinical guidelines, disease management, and other evidence-based medicine when applicable for treatment of the enrollee's healthcare issues and timing of clinical preventive services
<p>b. Electronic registry/patient tracking for key conditions</p> <ul style="list-style-type: none"> ◆ Maintain electronic patient registry capturing defined patient data elements for key conditions ◆ Provide current electronic report of patient status/outcomes to ASO Quarterly
<p>c. Designated care coordination responsibility</p> <ul style="list-style-type: none"> ◆ Primary Care Medical Home contact who facilitates the enrollee's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate ◆ Staff formally designated at site as primarily responsible for coordinating patient's healthcare services and to serve as a point of contact for the ASO's care managers ◆ Collaboration with ASO care manager efforts to provide care coordination and case management
<p>4) Provide Self-Care and Community Support</p>
<p>a. Patient/Family education on PCMH roles and participation</p> <ul style="list-style-type: none"> ◆ Provide information regarding medical home role, patient/family participation, service/network requirements and options for changing medical home assignment ◆ Provide information regarding LIHP Program policies, women's health access, Second Opinions, Appeals and Grievances. ◆ Provide information, forms and counseling on Advance Directives to patients and families
<p>b. Education and Self-Management Support (Identify, information)</p> <ul style="list-style-type: none"> ◆ Health information, education and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner ◆ Assist patients and their families in self-care management with information, tools and resources.
<p>5) Track and Coordinate Care</p>
<p>a. Coordination/co-management w/specialty providers</p> <ul style="list-style-type: none"> ◆ Care coordination across the service delivery system, facilitating communication among enrollee's healthcare providers, including mental health providers.

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Attachment A – LIHP Primary Care Medical Home

<p>b. Referral/Specialty Care Coordination (referral/response tracking)</p> <ul style="list-style-type: none"> ◆ Care management, disease management, case management, and coordination of transitions among levels of care, as needed ◆ Track and coordinate tests, referrals and transitions of care ◆ Referrals to qualified professionals, community resources, or other agencies as needed in accordance with LIHP utilization management policies/protocols ◆ Coordinate care with services received from other providers
<p>c. Follow-up on Discharge Summary/Discharge Instructions Received</p> <ul style="list-style-type: none"> ◆ Track and coordinate follow-up and transitions of care with the goal of reducing preventable Emergency Department visits, hospitalizations and readmissions ◆ The clinic care coordinator will be the designated personnel at each PCP site to receive enrollee discharge summaries and discharge instructions for enrollees seen at an ED or hospital. The ED and hospital are requested to send this information to the designated clinic site within 24 hours of an ED visit or hospital discharge.
6) Measure and Improve Performance
<p>a. Monitoring/Reporting on Access Standards</p> <ul style="list-style-type: none"> ◆ Review access/audit reports received from the ASO within 30 days of receipt ◆ Submit Corrective Action Plan to the ASO within 30 days, as needed
<p>b. Patient Experience/Satisfaction Surveys (annual – all patients)</p> <ul style="list-style-type: none"> ◆ Conduct (have conducted) and submit patient satisfaction surveys to ASO, at least annually ◆ ASO to conduct LIHP member satisfaction surveys
<p>c. ED/Hospital Utilization</p> <ul style="list-style-type: none"> ◆ Clinic site Care Coordinators to work with ASO to address the following: <ol style="list-style-type: none"> 1) ED Visits 2) ED Visits/Admissions for Avoidable Conditions 3) Readmission rates
<p>d. Clinical Outcomes for Chronic Disease Management Patients</p> <ul style="list-style-type: none"> ◆ Compliance with protocols for CDM registry reports

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Attachment A – LIHP Primary Care Medical Home

e. Selected Clinical Outcome/HEDIS Measures

- ◆ Participate in LIHP QI Program; maintain and report selected HEDIS Measures Quarterly to the ASO

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Attachment B – LIHP Appeals & Grievance Policy for Health Services

Appeals & Grievance Policy for the Low Income Health Program Health Services

ENROLLEE RIGHTS & ISSUE RESOLUTION

Enrollee Rights and Protections Under Federal Code

According to 42 CFR 438.100, and the California Bridge to Reform Demonstration Special Terms and Conditions (STC) #76, the Low Income Health Program (LIHP) is responsible for ensuring compliance with consumer rights and protections. Providers, as contractors of the LIHP, are also required to comply with all applicable regulations regarding consumer rights and protections. These rights and protections from 42 CFR can be summarized as follows:

- *Dignity, respect, and privacy.* Each LIHP enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the LIHP and available treatment options.* Each LIHP enrollee is guaranteed the right to receive information on the LIHP and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions.* Each LIHP enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion.* Each LIHP enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.
- *Copy of medical records.* Each LIHP enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Part 164.524 and 164.526.
- *Right to health care services.* Each LIHP enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206–210.

In accordance with 42 CFR, the Administrative Services Organization (ASO) distributes the LIHP Enrollee Guide to Low Income Health Program, which contains information on enrollee rights, as well as a description of the services available through the LIHP, and the avenues to obtain resolution of dissatisfaction with the LIHP services.

Additional Enrollee Rights

- **Provider Selection**

In accordance with 42 CFR 438.6, providers are reminded that LIHP enrollees have the right to obtain a list of LIHP providers from the LIHP program (County or ASO) or their PCMH,

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including information on their location, type of services offered, and areas of cultural and linguistic competence.

- **Second Opinion**

An LIHP enrollee may request a second opinion. A second opinion provides the enrollee with an opportunity to receive additional input on his or her health care. The enrollee makes their request for a second opinion to their provider. In turn, the medical primary care provider submits a Treatment Authorization Request to the ASO for approval.

- **Transfer from One Provider to Another**

Enrollees have a right to request a transfer from one LIHP provider to another.

- **Right to Language, Visual and Hearing Impairment Assistance**

Enrollees shall be routinely informed about the availability of free language assistance at the time of accessing services. Providers must also be able to provide information on Low Income Health Program services to enrollees with visual or hearing impairment or other disability, making every effort to accommodate individual's preferred method of communication.

Advance Health Care Directive Information

Federal regulations (42 CFR 422.128) require that all LIHP beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all new enrollees be given this information at their first face-to-face contact for services. An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new enrollees:

1. Provide written information on the enrollee right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new enrollee, and thereafter, upon request.
2. Document in the enrollee's medical record that this information has been given and whether or not the enrollee has an existing Advance Directive.

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3. If the enrollee who has an Advance Directive wishes to bring in a copy, the provider shall add it to the enrollee's current medical record.
4. If an enrollee is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the enrollee at the appropriate time. In the interim, the provider may choose to give a copy of the information to the enrollee's family or surrogate.
5. The provision of care will not be conditioned or the enrollee otherwise discriminated against based on the contents of an Advance Directive.
6. Should the situation ever arise, the provider shall offer information about the State contact point to enrollees who wish to complain about non-compliance with an Advance Directive.

The LIHP provides an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new enrollees or members of the community who request it. Copies may be obtained through the LIHP's ASO Medical Management Services Department at (858) 658-8650, or providers may duplicate their own copies. The LIHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Enrollees' Rights

Written and oral information that informs enrollees of their right to file an internal grievance or appeal and the procedures for exercising this right, as well as the right to appeal an action as identified herein to a State fair hearing upon exhaustion of the internal process, shall be provided to new enrollees upon first admission to the LIHP, along with the LIHP Enrollee Handbook.

- Grievance and Appeal
- Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all providers within the LIHP network at the time they enter into a contract, or when the LIHP begins, whichever is earlier.
- The LIHP will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability for all stages of the grievance and appeal processes, at no cost to applicants or enrollees.

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ENROLLEE PROBLEM RESOLUTION PROCESS

The LIHP is strongly committed to honoring the rights of every enrollee to have access to a fair, impartial, effective process through which the enrollee can seek resolution of a problem encountered in accessing or receiving quality medical and mental health services. All contracted providers are required to participate fully in the Enrollee Problem Resolution Process (Grievance and Appeal Process).

Enrollees shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The enrollee shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the enrollee is not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

Definitions

A. An “action” is:

1. A denial or limited authorization of a requested LIHP service, including the type or level of service.
2. A reduction, suspension, or termination of a previously authorized service.
3. A failure to provide the LIHP services in a timely manner pursuant to the Special Terms and Conditions of the California Bridge to Reform Demonstration for the LIHP.
4. A failure of the LIHP to act within the timeframes for grievances and appeals as outlined herein.

B. A “grievance” is an expression of dissatisfaction about any matter other than an action, as “action” is defined above.

C. An “appeal” is defined as a request for review of an action, as defined in A., above.

Problem Resolution at Provider Sites of Service

Enrollees are encouraged to direct their suggestions directly to the staff or management at the site where they have received services. This can be done orally or in writing. In attempting to reach resolution consistent with confidentiality requirements, staff or management shall utilize whatever information, resources and/or contacts the consumer agrees to.

Providers shall inform all enrollees about their right to file a grievance with the LIHP ASO if the enrollee has an expression of dissatisfaction about any matter, is uncomfortable approaching clinic or program staff, or the dissatisfaction has not been successfully resolved at the site of service.

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Grievance Process

Timeline: The enrollee must file an internal grievance within 60 calendar days of the incident giving rise to the grievance. In turn, the LIHP has 60 calendar days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A “Grievance” has been defined as an expression of dissatisfaction about any matter other than an action. Grievances will not be appealable to a State Fair Hearing.

An LIHP enrollee may contact the ASO for a grievance about the LIHP services which the enrollee was not able to resolve satisfactorily at the site of service. If the enrollee contacts a Patient Advocacy Organization rather than the ASO with a complaint, the ASO will be contacted by the Patient Advocacy Organization and the grievance process will be initiated with the ASO as appropriate.

The enrollee may submit a Grievance by sending a signed statement within 60 calendar days of the date of the irreconcilable encounter to:

LIHP Customer Service Supervisor
P.O. Box 23667
San Diego, CA 92193

The LIHP shall acknowledge in writing receipt of Grievance within 3 working days of receipt. If the signed statement is sent after 60 calendar days, the enrollee must explain the reason in that statement as to why the request for grievance was received late. The LIHP shall review and send the written decision to the enrollee within 45 calendar days of receiving the statement.

- The decision maker must not be involved in any previous level of review or decision making.
- The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the enrollee’s condition or disease: A grievance regarding denial of expedited resolution of an appeal, or a Grievance that involves clinical issues.

Administrative Review

If the provider and ASO cannot successfully resolve the enrollee’s grievance or appeal, the ASO will issue a finding, to be sent to the enrollee and provider, which may include the need for a Plan of Correction to be submitted by the provider to the ASO Medical Director or designee within 10 days of receipt. In the rare instances when the provider disagrees with the disposition of the grievance and/or does not agree to write a Plan of Correction, the provider may write to the ASO Medical Director or designee within 10 days, requesting an administrative

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review. The ASO Medical Director or designee shall have the final decision about needed action. If needed, administrative review of the grievance will be conducted by the governing body of the LIHP Quality Management Unit.

Appeal Process

- **Timeline:** Enrollees must file an appeal of action within 60 calendar days of the date of the notice of action. The ASO must mail written notice containing the resolution of the appeal within 45 calendar days of receipt of the appeal. Timeframes on the resolution of the appeal may be extended by up to 14 calendar days if either the enrollee requests it, or the ASO can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
- Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by the ASO unless the applicant, enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.
- Enrollees and their representatives will have the opportunity, before and during the appeals process:
- To examine the LIHP's position statement related to the reason services are delayed, denied or withdrawn by the LIHP, the enrollee's case file, including medical records, and any other documents under consideration in the appeal, and
- To confront and cross-examine adverse witnesses.
- Enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual.
- In regard to the option for enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:
- Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge,
- The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with this policy.
- Enrollees and their representatives must have the opportunity, before, and during the appeals process, to examine the LIHP's position statement, the enrollee's case file, including medical records, and any other documents under consideration in the appeal.

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- Enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal.
- The record will be kept open for 15 calendar days to permit enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.
- Enrollees and their representatives must be able to obtain reimbursement of enrollee costs in order to attend an in-person hearing, i.e. transportation.
- Change in Process
- At any point prior to or during a telephone or video conference hearing, at the request of either party or on the motion of the judge, an in-person hearing can be ordered.
- If an individual has an in person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

Appeals are enrollee or provider requests for reviews of actions by the LIHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner.

Appeals may be initiated in writing or verbally by the enrollee or provider with the ASO. The ASO organization will contact the enrollee or provider within three (3) working days of receiving the appeal. The ASO shall investigate the appealed matter. The LIHP (ASO Medical Director or designee) will review the appeal and make a decision on the appealed matter.

The enrollee may send a written appeal within 60 calendar days from the date of the Denial decision notice to:

LIHP Customer Service Supervisor
P.O. Box 23667
San Diego, CA 92193

The ASO Customer Service Supervisor shall explain the enrollee's rights and inform the enrollee what steps need to be taken to initiate an Appeal. The ASO shall send the enrollee a written decision by certified mail within 20 County business days after receiving an appeal.

- The decision maker must not be involved in any previous level of review or decision making.

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- The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the enrollee's condition or disease:
- An appeal of a denial based on lack of medical necessity.
- An appeal that involves clinical issues.

Expedited Appeal Process

Timeline:

- Expedited resolution of appeals – the LIHP must mail written notice within 3 working days of receipt of the appeal. In addition, reasonable efforts to provide oral notice will be made.
- Timeframes on the above may be extended by up to 14 calendar days if either the enrollee requests it, or the ASO can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the enrollee's interest.
- When the standard appeal process could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee may file a request for an expedited appeal, necessitating a very rapid turnaround from grievance to resolution. The request for expedited resolution may be made orally or in writing.

The ASO Medical Director or designee will make a decision if the request for an expedited appeal is granted by the third working day after receipt of request for the expedited appeal, and will notify the enrollee and the provider of the decision. If so, the ASO must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the enrollee's health condition requires and no later than 3 working days. The 3 working days time period may be extended by up to 14 calendar days if the enrollee requests an extension or if the LIHP justifies a need for additional information and how the extension is in the enrollee's interest.

State Fair Hearings

LIHP enrollees filing an appeal may request a State Fair Hearing, after exhausting the LIHP Enrollee Appeal Process with the ASO.

Matters outside the scope of the grievance and appeal process, including the right to a State Fair Hearing, include:

- A. The sole issue is one of Federal or State law or policy, LIHP protocols approved under the Demonstration Standards, Terms and Conditions (STC). (42 C.F.R. 431.230(1).)
- B. The establishment of and any adjustments to the upper income limit made by the LIHP, in accord with STC 58(b).

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- C. The establishment by an LIHP of enrollment caps of HCCI, and if as the result of such cap the HCCI is completely closed, establishment of enrollment caps for MCE. (STC 58(c).)
- D. The establishment by an LIHP of wait lists as a result of enrollment caps created in accord with STC 58(c). (STC 58(d).)
- E. The requirement that an LIHP make a timely eligibility determination is waived with respect to individuals' eligibility for a capped program while those individuals are placed on a county wait list for that program. The County's determination to place individuals on a wait list, rather than enrolling them in the capped program directly, is not subject to appeal. Nothing in this provision shall preclude those individuals from appealing the County's determination of eligibility for other programs.

State Fair Hearing

- A State fair hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the internal appeal of an action.
- The State will take final administrative action in accord with 42 CFR 431.244(f)(1), or 431.244(f)(2), if applicable.
- The LIHP will be a party to the State fair hearing.
- Continuation of benefits during an appeal of action or a State fair hearing
- The enrollee's benefits must be continued if:
 - An enrollee's eligibility is terminated or reduced;
 - The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - The services were ordered by an authorized provider;
 - The original period covered by the original authorization has not expired;
 - The enrollee or provider (on behalf of the enrollee) timely files an appeal; and
 - The enrollee requests extension of benefits.
- "Timely filing" as used in this section means filing on or before the later of either:
 - a) Ten (10) calendar days from the mailing of the notice of action
 - b) The intended effective date of the proposed action.
 - c) In the case of a State fair hearing, 10 calendar days from the date of the internal appeal decision.
- Benefits that are continued under this section shall be continued until:
 - a) The enrollee withdraws the appeal;

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- b) Ten (10) calendar days pass after the mailing of a notice resolving the internal appeal adverse to the enrollee, unless the enrollee requests a State fair hearing with continuation of benefits within 10 calendar days of the issuance of the internal appeal decision;
- c) A State fair hearing decision adverse to the enrollee is issued,
- d) As ordered by the Administrative Law Judge at the State fair hearing, in limited permissible circumstances, such as 431.230(a)(1); or
- e) The time period or service limits of a previously authorized service has been met.
- If the final resolution of the internal appeal or the state fair hearing is adverse to the enrollee, the LIHP may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent they were furnished solely because of the requirements of this section of the procedures.
- If services were not furnished pending the internal appeal or the State fair hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the LIHP must provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.
- If the enrollee received disputed services while the internal appeal or the State fair hearing was pending, and the resolution reverses a denial of services, the LIHP must cover such services.

Monitoring the Enrollee Problem Resolution Process and Medical Grievance & Appeal Process

The ASO, operating from a shared concern with providers about improving the quality of care and service, shall review feedback from the Grievance and Appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing Quality Management Plan, contract monitoring and/or credentialing process.

ENROLLEE NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

The following Notice of Action (NOA) forms or Position Statements will be used to notify enrollees about service provision:

- Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all enrollees at the same time that a Notice of Action is issued. Notices regarding standard authorization of service that deny or limit services will be provided as expeditiously as the enrollee's health condition requires and within 14 calendar days following receipt of the request for service. The timeframe may be extended for up to 14 additional calendar days if the enrollee or provider requests the extension, and the

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ASO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

Issuing of an NOA begins the 90-day period that an enrollee has to file for a State Fair Hearing. The following procedures shall be followed by ASO when issuing a Notice of Action–Mental (NOA–M), Notice of Action Physical (NOA–P):

1. The Notice of Action – Mental Health Form is utilized in the event a mental health service is denied. Written notification is mailed to the enrollee within 14 days of receipt of the request for service. The enrollee has the option to employ the Enrollee Problem Resolution Process to voice dissatisfaction with the denial of services.
2. The Notice of Action – Physical Health Form is written notification to the enrollee that their request for specialty medical services was denied. Written notification is mailed to the enrollee within 14 days of receipt of the request for service.

The NOA form informs the LIHP enrollee of the following:

- The intended denial
- Reason for denial (including statutory and regulatory references, if applicable);
- The effective date of the action
- Enrollee's right to a second opinion
- The Appeal process and the enrollee's right to file an appeal
- The circumstances under which expedited resolution is available and how to request it
- Right to a State Fair Hearing (once local process has been exhausted)
- Criteria for an expedited State Fair Hearing
- The circumstances under which benefits are continued and how to request it. (42 CFR 438.404.)
- LIHP Monitoring Reporting

The ASO will maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process on a quarterly basis..

- A. Time Period(s) Covered
- B. Average Number of LIHP enrollees in the time period
- C. Total number of appeal and the total number of grievance cases received by the LIHP or the State in the period;
- D. Rate of Appeals and the rate of grievances
- E. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of;
 - a) Number and percent decided in fully favor of the LIHP enrollee

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- b) Number and percent decided partially in favor of the LIHP enrollee
- c) Number and percent not decided in favor of the LIHP enrollee
- d) Number and percent withdrawn by the LIHP enrollee;
- e) Number and percent of cases resolved through the fair hearing process, using telephonic procedures
 - i) Number and percent decided in fully favor of the LIHP enrollee using telephonic procedures
 - ii) Number and percent decided partially in favor of the LIHP enrollee using telephonic procedures
 - iii) Number and percent not decided in favor of the LIHP enrollee using telephonic procedures
 - iv) Number and percent withdrawn by the LIHP enrollee using telephonic procedures;
- F. Issues involved in all cases.
- G. Time it takes to resolve the cases (upper and lower limits, median/mean)
 - a) Number and percent of these cases involving expedited processing; and
- H. Quality Improvement activities related to issues identified through the County's LIHP.

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Attachment C – LIHP Quality and Utilization Management

The ASO will coordinate QM and UM efforts and provide case management and/or care coordination to LIHP/CMS enrollees with complex health conditions and co-morbidities who may be at risk for adverse outcomes, under or over-utilization of services.

Identification, Risk Stratification and Health Risk Assessment:

- The ASO utilizes predictive modeling and care management models to risk stratify enrollees.
 - Chronic Disease – e.g. Asthma, HTN, Diabetes
 - Pharmacy Data—Diabetes, Narcotic Use
 - Inpatient Bed Days
- The ASO classifies enrollees as High, Moderate, or Low Risk
- The ASO determines the priority and frequency of outreach activities based on risk level of the client.

Implement & Monitor:

The efforts of Case Management and Care Coordination address:

- Hospital utilization
- Emergency Department utilization
- Specialty care referral utilization
- High-cost, high-need beneficiaries
- Quality Management Measures
- Provider access and network adequacy
- Cultural competency/sensitivity
- Status of the FQHCs as patient-centered medical homes
- Assist/facilitate county compliance with the LIHP Access Standards
- Integration of mental health and physical health care services

The LIHP/CMS Quality Management committee (formerly known as the CMS/CI Quality Management Committee) will maintain oversight of the LIHP/CMS Case Management/Care Coordination. The Quality Management Committee, chaired by the Medical Director of the ASO, is comprised of the LIHP primary care and specialty providers along with ASO and HHSA representatives. The committee oversees the development and implementation of the annual quality management plan. All providers are required to follow the requests for data and the implementation plans for quality improvement as delineated in the LIHP Annual QM plan.

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Attachment D – LIHP Cultural Competency

Reference: LIHP STC 73, 42 C.F.R. § 438.206(c)(2), 42 C.F.R. § 438.100(a),(b), (c).

Background:

Based on the LIHP STC 73, 42 C.F.R. § 438.206(c)(2), 42 C.F.R. § 438.100(a),(b), (c) and Title VI of the Civil Rights Act of 1964, U.S. Code 2000(d)– when a need is determined, the County of San Diego Health and Human Services Agency (HHS) – Low Income Health Program (LIHP) shall ensure that a process is in place for accommodating and referring clients to available culturally and/or linguistically appropriate services. Title VI of the Civil Rights Act of 1964 prohibits the denial of access to federally–assisted programs and activities because of limited English proficiency. Providers are required to provide language assistance to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

Purpose:

To ensure that all enrollees requesting services at the LIHP network of care (e.g. clinics, providers and hospitals) providing the LIHP scope of services have been evaluated for needing culturally/linguistically specialized services and linked with these services or referred appropriately.

Policy:

Cultural competence is a key element in providing high–quality health care to the diverse population of San Diego County. The LIHP will make ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of the enrollees.

Enrollees have a right to a choice of providers whenever possible, and cultural and linguistic preferences shall be considered in making appropriate referrals. At the point of entry into a network clinic, provider or hospital, the cultural and/or linguistic needs of an individual shall be assessed and all reasonable efforts made to accommodate, refer and/or link them to appropriate services reflecting those preferences. In this context, cultural needs may include special referral needs, such as homelessness. Enrollees shall be informed of the availability for free interpretation services. Written materials specified by state and federal regulations shall be available in threshold languages.

Free interpreter services shall be available to enrollees with Limited English Proficiency (LEP) in the enrollee’s primary language to assist in the delivery of health and mental health services, and non–health care services (e.g. customer service, orientations, appointment scheduling, etc.) This service is available for the LIHP network of care. Other limited or specific interpreter services may be approved by the Contracting Officer’s Technical Representative (COTR).

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Procedure:

The LIHP will ensure ongoing progress toward meeting service availability based on the cultural and linguistic needs of the enrollees requiring physical health and mental health services by:

1. Analyzing demographic information changes periodically to determine or identify gaps in service provision.
2. Reflecting cultural and linguistic needs in strategic plans, policies and procedures, human resource training and recruitment, and contracting requirements.
3. Ensuring Clinical Practice Standards for Cultural Competence will be incorporated in physical and mental health service provision.
4. Periodically assessing and adjusting contract language to reflect changing cultural competence needs in the selection of contract providers.
5. Providing and fostering the provision of training in cultural competencies on a wide variety of cultures, including client culture, sensitivity or diversity training for staff, providers, administration, and interpreter services.
6. Analyzing enrollee and staff satisfaction survey results, and grievances and appeals, to determine areas of needed cultural and linguistic service improvement.

All enrollees with the LIHP shall be informed in a language they understand that they have a right to free oral interpretation assistance. The availability of free interpretation assistance will be publicized in the LIHP Provider Handbooks and Enrollee Handbooks. Fully translated written informing materials are available to all LIHP enrollees.

LIHP Provider expectations:

1. Providers shall inform enrollees of their right to receive help from an interpreter and document the response to the offer. Upon request of the enrollee, providers shall arrange for language assistance.
2. Providers are expected to support staff's language competency for languages provided within the provider site. If provider staff can meet the need for language assistance, then the program shall provide the services.
3. If the provider cannot meet the need for language service, then provider staff shall:
 - a. Call the selected interpreter service to determine availability and schedule service. LIHP providers should request a "qualified" interpreter. ("Certified" interpreters are requested primarily for legal cases.)

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- Interpreters Unlimited (for language interpreting) (800) 726-9891
Fax Number: (800) 726-9822
 - Deaf Community Services (deaf and hearing impaired) (619) 398-2441
Fax Number: (619) 398-2490
 - Network Interpreting Service (800) 284-1043
Fax Number: (815) 425-9244
 - CTS Language Link (Interpreter Service, Telephone Base) (800) 208-2620
 - Language Line (Interpreter Service, Telephone Base) (800) 752-6096
 - Telecommunications Device (TDD) or (TTY) (619) 398-2440
 - Telecommunications Relay Services 711
- b. Fax interpreter invoice and supporting documentation to County at 858-492-2265 or mail to 8840 Complex Dr. Suite 255 San Diego, CA 92123
- c. Any services not cancelled 24 hours in advance will still be billed to the LIHP
- *Please share this information with all staff/enrollees/family members and ask them to contact their provider in a timely manner when they must cancel an appointment utilizing interpreter services.*
- d. LIHP will review invoice, supporting documentation, and verify the LIHP enrollee
- e. If criteria met, the LIHP will pay invoice

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Attachment E – LIHP Primary Care Clinic QM Plan

LIHP Primary Care Clinic QM Plan Approved for 2011

Chronic Disease	Monitoring Parameters	Sources/Benchmark
DIABETES (all ages) <ul style="list-style-type: none"> HbA1c LDL Blood Pressure 	<p><9.0</p> <p><100</p> <p><140/90</p>	<p>HbA1c: UDS, HEDIS, MU, AQIC</p> <p>LDL: HEDIS, MU, AQIC</p> <p>BP: HEDIS, UDS, MU</p>
HYPERTENSION <ul style="list-style-type: none"> Blood Pressure 	<140/90	UDS, HEDIS, ALL, MU, Right Care
ASTHMA <ul style="list-style-type: none"> Persistent asthma Age < 41 yo 	Use of appropriate medications for people with Asthma	HEDIS
Smoking Cessation <ul style="list-style-type: none"> All LIHP 	Preventive Care screening with smoking and tobacco use cessation	UDS, HEDIS, MU
CAD	Persistence of Beta Blocker treatment after heart attack	HEDIS
Mental Illness	Follow up after hospitalization for mental illness	HEDIS

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Attachment F – LIHP Network Dental Locations

Comprehensive Health Center

3177 Ocean View Boulevard
San Diego, CA 92113
(619) 231-9300

Fallbrook Family Health Center

1328 South Mission Road
Fallbrook, CA 92028
(760) 451-4720

Family Health Centers San Diego –

Grossmont/Spring Valley Dental

8788 Jamacha Road
Spring Valley, CA 91977
(619) 515-2330

Family Health Centers San Diego – Logan

Heights Dental Clinic

1809 National Avenue
San Diego, CA 92113
(619) 515-2394

**Family Health Centers San Diego – North
Park/Hillcrest Dental Clinic**

3544 30th Street
San Diego, CA 92104
(619) 515-2434

La Maestra Family Clinic – El Cajon

183 South First Street
El Cajon, CA 92019
(619) 328-1335

La Maestra Family Clinic

4305 University, Suite 120
San Diego, CA 92105
(619) 285-8135

Neighborhood Healthcare –

Lakeside Dental

10039 Vine Street
Lakeside, CA 92040
(619) 390-9975

Neighborhood Healthcare – Pauma Valley

16650 Hwy. 76
Pauma Valley, CA 92061
(760) 742-9919

Neighborhood Healthcare – Ray M.

Dickinson Wellness Center

425 North Date, Suite 125
Escondido, CA 92025
(760) 737-2018

Operation Samahan – Camino Ruiz

10737 Camino Ruiz, Suite 235
San Diego, CA 92126
(858) 578-4220

Operation Samahan—Highland

2743 Highland Avenue
National City, CA 91950
(619) 474-2284

San Ysidro Health Center

4004 Beyer Boulevard
San Ysidro, CA 92173
(619) 662-4180

Vista Community Clinic

1000 Vale Terrace
Vista, CA 92084
(760) 631-5000

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***Alvarado Hospital**

6655 Alvarado Road
San Diego, CA 92120
(619) 287-3270

Fallbrook Hospital District

624 East Elder Street
Fallbrook, CA 92028
(760) 728-1191

***Palomar Hospital Medical Center**

555 East Valley Parkway
Escondido, CA 92025
(760) 739-3000

***Paradise Valley Hospital**

2400 East Fourth Street
National City, CA 91950
(619) 470-4321

***Pomerado Hospital**

15615 Pomerado Road
Poway, CA 92064-2405
(858) 613-4000

***Promise Hospital of San Diego**

5550 University Avenue
San Diego, CA 92105
(619) 582-3516

Scripps Memorial – Encinitas

354 Santa Fe Drive
Encinitas, CA 92024
(760) 753-6501

Scripps Memorial – La Jolla

9888 Genesee Avenue
La Jolla, CA 92037
(858) 457-4123

***Scripps Mercy Hospital**

4077 Fifth Avenue
San Diego, CA 92103
(619) 294-8111

Scripps Mercy Hospital – Chula Vista

435 H Street
Chula Vista, CA 91910
(619) 691-7000

Sharp Chula Vista Medical Center

751 Medical Center Court
Chula Vista, CA 91911
(619) 482-5800

Sharp Coronado Hospital

250 Prospect Place
Coronado, CA 92118
(619) 522-3600

***Sharp– Grossmont Hospital**

5555 Grossmont Center Drive
La Mesa, CA 91942
(619) 740-6000

Sharp Memorial Hospital

7901 Frost Street
San Diego, CA 92123
(858) 939-3400

***Tri-City Medical Center**

4002 Vista Way
Oceanside, CA 92056
(760) 724-8411

***UCSD Medical Center**

200 West Arbor Drive
San Diego, CA 92103
(619) 543-6222

County of San Diego Low Income Health Program (LIHP)
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UCSD Thornton Hospital
9300 Campus Point Drive
La Jolla, CA 92037
(858) 550-0115

*** Hospitals that provide inpatient psychiatric services.**

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*****Alvarado Parkway Institute**

7050 Parkway Dr.
La Mesa, CA 91942
(619) 465-4411

***Promise Hospital of San Diego**

5550 University Avenue
San Diego, CA 92105
(619) 582-3800

****Bayview Hospital**

330 Moss St.
Chula Vista, CA 91911
(619) 426-6310

***Scripps Mercy Hospital**

4077 Fifth Avenue
San Diego, CA 92103
(619) 294-8111

***Palomar Pomerado Health System**

555 East Valley Parkway
Escondido, CA 92025
(760) 739-3240

***Sharp – Grossmont Hospital**

5555 Grossmont Center Drive
La Mesa, CA 91942
(619) 740-6000

***Paradise Valley Hospital**

2400 East 4th Street
National City, CA 91950
(619) 470-4321

*****Sharp Mesa Vista**

7850 Vista Hill Ave.
San Diego, CA 92123
(858) 278-4110

***Pomerado Hospital**

15615 Pomerado Road
Poway, CA 92064-2405
(858) 613-4000

***Tri-City Medical Center**

4002 Vista Way
Oceanside, CA 92056
(760) 940-7396

***UCSD Medical Center**

415 Dickinson Street
San Diego, CA 92103
(619) 543-6222

* Hospitals that provide inpatient psychiatric services

** Psychiatric hospital services only

*** Psychiatric Hospital services for 19 and 20 year-olds only

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BORREGO SPRINGS MEDICAL CENTER

4343 Yaqui Pass Road
Borrego Springs, CA 92004
(760) 767-5051

Centro Medico—El Cajon

396 North Magnolia
El Cajon, CA 92020-3954
(619) 401-0404

Borrego Julian Medical Clinic

2721 Washington Street
Julian, CA 92036
(760) 765-1223

COMMUNITY HEALTH SYSTEMS

Fallbrook Family Health Center

1328 South Mission Road
Fallbrook, CA 92028
(760) 451-4720

**FAMILY HEALTH CENTERS (FHC) OF SAN
DIEGO**

Beach Area FHC

3705 Mission Boulevard
San Diego, CA 92109
(619) 515-2444

Chase Avenue FHC

1111 West Chase Avenue
El Cajon, CA 92020
(619) 515-2499

**FAMILY HEALTH CENTERS (FHC) OF SAN
DIEGO (Continued)**

Chula Vista FHC

251 Landis Avenue
Chula Vista, CA 91910
(619) 515-2500

City Heights FHC

5379 El Cajon Boulevard
San Diego, CA 92115
(619) 515-2400

Diamond Neighborhoods FHC

220 Euclid Avenue, Suite 40
San Diego, CA 92114
(619) 515-2560

Downtown FHC

1145 Broadway
San Diego, CA 92101
(619) 515-2525

Grossmont/Spring Valley FHC

8788 Jamacha Road
Spring Valley, CA 91977
(619) 515-2555

Lemon Grove FHC

7592 Broadway
Lemon Grove, CA 91945
(619) 515-2550

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FAMILY HEALTH CENTERS (FHC) OF SAN DIEGO (Continued)

Logan Heights FHC

1809 National Avenue
San Diego, CA 92113
(619) 515-2300

North Park FHC

3544 30th Street
San Diego, CA 92104
(619) 515-2424

Sherman Heights FHC

2391 Island Avenue
San Diego, CA 92102
(619) 515-2435

IMPERIAL BEACH HEALTH CENTER

949 Palm Avenue
Imperial Beach, CA 91932
(619) 429-3733

LA MAESTRA FAMILY CLINIC

4060 Fairmount Avenue
San Diego, CA 92105
(619) 280-4213

El Cajon

165 South First Street
El Cajon, CA 92019
(619) 312-0347

National City Clinic

101 North Highland Avenue, Unit A
National City, CA 91950
(619) 434-7308

MOUNTAIN HEALTH & COMMUNITY SERVICES

Alpine Family Medicine

1620 Alpine Boulevard #B119
Alpine, CA 91901
(619) 445-6200

Escondido Family Medicine

255 North Ash Street, Suite 101
Escondido, CA 92027
(760) 745-5832

Mountain Empire Family Medicine

31115 Highway 94
Campo, CA 91906
(619) 478-5311

25th Street Family Medicine

316 25th Street, Suite 101
San Diego, CA 92102
(619) 238-5551

NEIGHBORHOOD HEALTHCARE

El Cajon

855 East Madison
El Cajon, CA 92020
(619) 440-2751

Lakeside

10039 Vine Street
Lakeside, CA 92040
(619) 390-9975

Escondido –North Elm

460 North Elm Street
Escondido, CA 92025
(760) 737-2000

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NEIGHBORHOOD HEALTHCARE

(continued)

Escondido –Grand

1001 E. Grand Ave.
Escondido, CA 92025
(760) 520-8200

Pauma Valley

16650 Highway 76
Pauma Valley, CA 92061
(760) 742-9919

Ray M. Dickinson Wellness Center

425 North Date Street, Suite 203
Escondido, CA 92025
(760) 520-8300

NORTH COUNTY HEALTH SERVICES

Ramona Health Center

217 East Earlham Street
Ramona, CA 92065
(760) 789-1223

OPERATION SAMAHAN

Health Clinic

10737 Camino Ruiz, Suite 100
San Diego, CA 92126
(858) 578-4220

Family Clinic

2743 Highland Avenue
National City, CA 91950
(619) 474-8686

OPERATION SAMAHAN

(continued)

Community Health Center

2835 Highland Ave., Ste A
National City, CA 91950
(619) 474-5567

SAN DIEGO AMERICAN INDIAN HEALTH CTR.

2630 First Ave
San Diego, CA 92103
(619) 234-2158

SAN DIEGO FAMILY CARE

Linda Vista Health Care Center

6973 Linda Vista Road
San Diego, CA 92111
(858) 279-0925

Mid City Community Clinic

4290 Polk Avenue
San Diego, CA 92105
(619) 563-0250

SAN YSIDRO HEALTH CENTER

4004 Beyer Boulevard
San Ysidro, CA 92173
(619) 428-4463

Chula Vista Family Clinic

865 Third Avenue, Suite 133
Chula Vista, CA 91911
(619) 498-6200

County of San Diego Low Income Health Program (LIHP)
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SAN YSIDRO HEALTH CENTER

(continued)

National City Family Clinic

1136 D Avenue
National City, CA 91950
(619) 336-2300

Otay Family Health Center

1637 Third Avenue, Suite B
Chula Vista, CA 91911
(619) 205-1360

Paradise Hills Family Clinic

2400 E. 8th Street, Ste A.
National City, CA 91950
(619) 662-4100

South Bay Family Health Center

(Urgent Care Clinic)

340 4th Avenue, Suite #7
Chula Vista, CA 91910
(619) 205-1960

Comprehensive Health Center—Euclid

286 Euclid Avenue, Suite 302
San Diego, CA 92114
(619) 527-7330

Comprehensive Health Center—Ocean View

3177 Ocean View Boulevard
San Diego, CA 92113
(619) 231-9300

ST. VINCENT de PAUL VILLAGE FAMILY CENTER

1501 Imperial Avenue
San Diego, CA 92101
(619) 233-8500

VISTA COMMUNITY CLINICS

Vista Community Clinic

1000 Vale Terrace
Vista, CA 92084
(760) 631-5000

Vista Community Clinic – Grapevine

134 Grapevine Drive
Vista, CA 92083
(760) 631-5030

Vista Community Clinic – Horne Street

517 N. Horne Street
Oceanside, CA 92054
(760) 631-5009

Vista Community Clinic – N. River Rd

4700 North River Road
Oceanside, CA 92057
(760) 433-6880

Vista Community Clinic – Pier View Way

818 Pier View Way
Oceanside, CA 92054
(760) 631-5250

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Areta Crowell

1963 4th Avenue
San Diego, CA 92101
(619) 233-3432

Douglas Young Center

10717 Camino Ruiz, Suite 207
San Diego, CA 92126
(858) 695-2211

East County Mental Health Center

1000 Broadway, Suite 210
El Cajon, CA 92021
(619) 401-5500

**Family Health Centers of San Diego –
Logan Heights Family Counseling Center**

2204 National Avenue
San Diego, CA 92113
(619) 515-2355

Heartland Center

1060 Estes Street
El Cajon, CA 92020
(619) 440-5133

North Central Mental Health Center

1250 Morena Blvd, 1st Floor
San Diego, CA 92110
(619) 692-8750

North Coastal Mental Health Center

1701 Mission Ave, Suite A
Oceanside, CA
(760) 957-4475

North Inland Mental Health Center

125 West Mission Ave, Suite 103
Escondido, CA 92025
(760) 747-3424

South Bay Guidance

835 3rd Ave, Suite C
Chula Vista, CA 91910
(619) 427-4661

Southeast Mental Health Center

3177 Ocean View Blvd
San Diego, CA 92113
(619) 595-4400